		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030015

Facility Name: WESTMONT CONVALESCENT CENTER

Address: 6501 SOUTH CASS AVENUE (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

Telephone Number: (630) 960-2026 **Fax #** (630) 960-0480

IDPA ID Number: 36-3376606

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[X]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) FLORA WEISS
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,420	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,055	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,475	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,005	3,542	8,482	21,029	8
9	SNF/PED					9
10	ICF	38,428	11,405	312	50,145	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,433	14,947	8,794	71,174	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.70%

D. How many bed-hold days during this year were paid by Public Aid?
272 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 43 and days of care provided 6,640

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	263,397	21,530	6,048	290,975		290,975		290,975			1
2	Food Purchase		245,139		245,139		245,139	(854)	244,285			2
3	Housekeeping	236,678	35,466		272,144		272,144		272,144			3
4	Laundry	129,017	16,831	5,990	151,838		151,838		151,838			4
5	Heat and Other Utilities			198,437	198,437		198,437		198,437			5
6	Maintenance	68,616	41,796	29,607	140,019		140,019	3,064	143,083			6
7	Other (specify):*			19,895	19,895		19,895		19,895			7
8	**TOTAL General Services**	697,708	360,762	259,977	1,318,447		1,318,447	2,210	1,320,657			8
	B. Health Care and Programs											
9	Medical Director			34,350	34,350		34,350		34,350			9
10	Nursing and Medical Records	2,322,181	143,770	156,359	2,622,310		2,622,310		2,622,310			10
10a	Therapy	151,928	423	2,723	155,074		155,074		155,074			10a
11	Activities	142,191	1,300	404	143,895		143,895		143,895			11
12	Social Services	93,030		1,111	94,141		94,141		94,141			12
13	Nurse Aide Training			5,422	5,422		5,422		5,422			13
14	Program Transportation			2,060	2,060		2,060		2,060			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,709,330	145,493	202,429	3,057,252		3,057,252		3,057,252			16
	C. General Administration											
17	Administrative	211,884		979,100	1,190,984		1,190,984		1,190,984			17
18	Directors Fees											18
19	Professional Services			40,273	40,273		40,273		40,273			19
20	Dues, Fees, Subscriptions & Promotions			31,657	31,657		31,657	(13,196)	18,461			20
21	Clerical & General Office Expenses	200,809	30,029	25,388	256,226		256,226	(20,498)	235,728			21
22	Employee Benefits & Payroll Taxes			641,530	641,530		641,530		641,530			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,917	3,917		3,917		3,917			24
25	Other Admin. Staff Transportation			63,615	63,615		63,615		63,615			25
26	Insurance-Prop.Liab.Malpractice			161,370	161,370		161,370		161,370			26
27	Other (specify):*			19,816	19,816		19,816	(19,816)				27
28	**TOTAL General Administration**	412,693	30,029	1,966,666	2,409,388		2,409,388	(53,510)	2,355,878			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,819,731	536,284	2,429,072	6,785,087		6,785,087	(51,300)	6,733,787			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			462,131	462,131		462,131	(61,543)	400,588			30
31	Amortization of Pre-Op. & Org.			21,180	21,180		21,180		21,180			31
32	Interest			678,503	678,503		678,503		678,503			32
33	Real Estate Taxes			86,917	86,917		86,917		86,917			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			74,784	74,784		74,784		74,784			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,323,515	1,323,515		1,323,515	(61,543)	1,261,972			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		170,477	270,027	440,504		440,504		440,504			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,713	117,713		117,713		117,713			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		170,477	387,740	558,217		558,217		558,217			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,819,731	706,761	4,140,327	8,666,819		8,666,819	(112,843)	8,553,976			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,543)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(854)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(6,281)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,816)	27		24
25	Fund Raising, Advertising and Promotional	(6,765)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(17,434)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (112,843)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (112,843)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
WESTMONT CONVALESCENT CENTER
ID# 0030015
Report Period Beginning: 01/01/2002
Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 3,064	6	1
2	DIRECTOR OF MARKETING	(20,498)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(17,434)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(854)	0	0	0	0	0	0	0	0	0	0	(854)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	3,064	0	0	0	0	0	0	0	0	0	0	3,064	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	2,210	0	0	0	0	0	0	0	0	0	0	2,210	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,196)	0	0	0	0	0	0	0	0	0	0	(13,196)	20
21	Clerical & General Office Expenses	(20,498)	0	0	0	0	0	0	0	0	0	0	(20,498)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(19,816)	0	0	0	0	0	0	0	0	0	0	(19,816)	27
28	**TOTAL General Administration**	(53,510)	0	0	0	0	0	0	0	0	0	0	(53,510)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,300)	0	0	0	0	0	0	0	0	0	0	(51,300)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(61,543)	0	0	0	0	0	0	0	0	0	0	(61,543)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(61,543)	0	0	0	0	0	0	0	0	0	0	(61,543)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(112,843)	0	0	0	0	0	0	0	0	0	0	(112,843)	45

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	FLORA WEISS	GEN. PARTNER	ADMINISTRAT.	0.22	0			MGMT FEE	$ 489,550	17-3	1
2	DANIEL WEISS	ASST. ADM	ADMINISTRAT.	0.00	SEE ATTACHED			SALARY	47,672	17-1	2
3	SHIRLEY HOLT	GEN. PARTNER	ADMINISTRAT.	0.16	0			MGMT FEE	489,550	17-3	3
4	RICHARD HOLT	GEN. PARTNER	SECURITY	0.00	0			OUTS. LAB.	4,750	6-3	4
5	NANCY GERACI	ADMINISTRATOR	ADMINISTRAT.	0.01	0			SALARY	109,212	17-1	5
6	SHARON HAUGH	BOOKKEEPER	CLERICAL	0.01	0			SALARY	43,541	21-1	6
7	JANE HOLT	MDS COMP. INPUT	COMP. INPUT	0.00	0			SALARY	12,000	10-1	7
8	VASCO HOLD	CLERK	IN SEV. TRAIN.	0.00	0			SALARY	25,200	10-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP. CONS.	0.00	SEE ATTACHED			SALARY	16,800	21-1	9
10	CAROLYN HOLT	CLERK	CLERICAL	0.00	0			SALARY	9,600	21-1	10
11											11
12											12
13								TOTAL	$ 1,247,875		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	KEY COMMERCIAL		X	MORTGAGE	$84,015.00	05/01/98	$ 10,000,000	$ 9,231,861	05/01/23	7.2800	$ 678,503	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$84,015.00		$ 10,000,000	$ 9,231,861			$ 678,503	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,000,000	$ 9,231,861			$ 678,503	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 76,300	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 81,217	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,917	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 82,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 86,917	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	70,426	8
	1998	72,625	9
	1999	72,603	10
	2000	75,156	11
	2001	81,217	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESTMONT CONVALESCENT CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0030015

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-22-101-001	NURSING HOME	$ 77,379.44	$ 77,379.44
2.	09-22-101-002	NURSING HOME	$ 3,837.10	$ 3,837.10
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,216.54	$ 81,216.54

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1995	$ 349,103	1
2					2
3	TOTALS			$ 349,103	3

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1995		$ 4,982,301	$ 127,751	39	$ 127,751	$	$ 995,517	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING			1986	41,641	2,165	19	2,165		34,448	9
10	ROOF & WATER LINE			1987	31,143	989	20	1,557	568	24,126	10
11	IMPROVEMENTS			1988	44,614	1,417	31.5	1,417		20,527	11
12	IMPROVEMENTS			1989	40,935	1,299	31.5	1,299		17,478	12
13	DRIVEWAY			1989	17,137	1,142	15	1,142		12,322	13
14	IMPROVEMENTS			1990	37,367	1,187	31.5	1,187		14,774	14
15	IMPROVEMENTS			1991	45,002	1,428	31.5	1,428		16,183	15
16	IMPROVEMENTS			1992	49,649	1,577	31.5	1,577		16,465	16
17	ROOF TOP A/C UNITS			1993	9,100	289	31.5	289		2,866	17
18	IMPROVEMENTS			1993	53,243	1,366	39	1,366		12,827	18
19	IMPROVEMENTS			1994	31,230	801	39	801		6,925	19
20	FLOOR COVERING			1995	795	20	15	53	33	424	20
21	HAND RAIL			1995	2,249	58	39	58		457	21
22	FLOOR TILES			1995	5,471	140	39	140		1,068	22
23	WINDOW A/C UNITS			1995	14,146	363	39	363		2,706	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056	309	39	309		2,331	24
25	ALARM			1995	1,337	34	39	34		254	25
26	LAUNDRY BUILDING			1995	35,000	897	39	897		6,541	26
27	ROOF			1995	5,520	142	39	142		1,035	27
28	WINDOWS			1995	9,478	243	39	243		1,752	28
29	DOOR EDGE & DOOR FRAME			1996	2,099	54	39	54		376	29
30	LAUNDRY BUILDING			1996	175,187	4,492	39	4,492		29,389	30
31	AIR COOLERS			1996	6,642	171	39	171		1,109	31
32	RACING CAGE			1996	3,987	102	39	102		667	32
33	HAND RAIL			1996	1,156	30	39	30		191	33
34	WINDOWS			1996	11,496	295	39	295		1,881	34
35	TACK ROOM			1996	2,139	55	39	55		346	35
36	NEW CONFERENCE ROOM-TILE			1997	2,938	76	39	76		402	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL DIETARY DOOR	1997	$ 1,478	$ 38	39	$ 38	$	$ 201	37
38	NURSING STATION - 2ND FLOOR	1997	5,397	138	39	138		708	38
39	WINDON-NURSING OFFICE	1997	1,382	35	39	35		179	39
40	REPLACEMENT A/C HEATING UNIT	1997	1,107	28	39	28		167	40
41	NURSING STATION - FLOOR TILES, HANDRAILS	1997	4,927	126	39	126		594	41
42	THE PARKING LOT	1998	42,711	2,990	15	2,990		11,768	42
43	KITCHEN BACK-REPLACE TILES, SIX ROOMS - INSTALL T	1998	6,223	160	39	160		783	43
44	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD	1998	12,715	326	39	326		1,345	44
45	GENERATOR BACK-UP HOOK-UP TO ELEVATOR	1999	10,473	269	39	269		1,065	45
46	REPLACEMENT OF WATER HEATER - 1ST FLOOR	1999	3,452	89	39	89		330	46
47	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL	1999	1,495	38	39	38		141	47
48	SEALCOATING, REPAIRS & LINING	1999	2,877	74	39	74		268	48
49	REMODELING F WING SHOWER ROOM	1999	8,988	230	39	230		815	49
50	REPLACE DEFECTIVE SMOKE DETECTORS	1999	2,370	61	39	61		211	50
51	THE NEW PROXIMITY ELEVATOR DOOR EDGE	1999	2,760	71	39	71		228	51
52	WATER HEATER - DIETARY	1999	2,931	75	39	75		234	52
53	ROOF TOP - TWO EXHAUST FANS	1999	3,073	79	39	79		247	53
54	TILE - DINING ROOM	1999	1,212	31	39	31		97	54
55	ROOF - REPAIRS AND COATINGS	1999	7,200	185	39	185		578	55
56	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT	1999	2,738	70	39	70		213	56
57	WINDOW TREATMENT, DRAPERY	2000	3,265	595	20	163	(432)	489	57
58	WATER HEATER - DIETARY	2000	3,573	130	27.5	130		298	58
59	GENERAL CONSTRUCTION	2000	27,448	998	27.5	998		2,204	59
60	ROOF REPAIR	2000	4,200	153	27.5	153		338	60
61	REPLACE ELECTRICAL PANEL INTERIOR	2000	2,910	106	27.5	106		216	61
62	NEW A/C UNIT ROOF TOP	2000	4,694	171	27.5	171		349	62
63	WALLCOVERING, FLOORING, LIGHTING	2000	80,523	15,847	20	4,026	(11,821)	12,078	63
64	SHOWER ROOM RENOVATIONS	2001	30,586	1,112	27.5	1,112		1,993	64
65	DURO-LAST ROOFING SYSTEMS	2001	107,341	3,903	27.5	3,903		5,367	65
66	WATER HEATER - LAUNDRY	2001	9,108	331	27.5	331		345	66
67	ROOF TOP - HEATING & COOLING UNITS	2001	12,464	453	27.5	453		472	67
68	WALLCOVERING, FLOORING, LIGHTING	2001	270,861	97,408	20	13,543	(83,865)	27,086	68
69	WALLCOVERING, FLOORING, CARPETING	2002	29,114	13,829	20	1,456	(12,373)	1,456	69
70	TOTAL (lines 4 thru 69)		$ 6,386,654	$ 289,041		$ 181,151	$ (107,890)	$ 1,298,250	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,386,654	$ 289,041		$ 181,151	$ (107,890)	$ 1,298,250	1
2	FURNISH BRICK PIERS & SIGN, ASPHALT REPAIRS	2002	8,997	180	15	180		180	2
3	SHOWER ROOM	2002	30,924	234	27.5	234		234	3
4	INSTALLED TWO ROOF TOP UNITS, FIRE DAMPER	2002	9,010	14	27.5	14		14	4
5	NEW NURSES STATION WITH CORIAN TOP	2002	14,891	23	27.5	23		23	5
6	2ND FLOOR CORRIDOR-WALLCOVERING, LIGHT FIXTUR	2002	40,056	13,419	20	2,003	(11,416)	2,003	6
7	PRIVATE ROOM-FLOORING, WALLCOV., BATHROOM	2002	11,499	3,852	20	575	(3,277)	575	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,502,031	$ 306,763		$ 184,180	$ (122,583)	$ 1,301,279	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,080,297	$ 136,181	$ 214,196	$ 78,015		$ 1,424,354	71
72	Current Year Purchases	26,866	19,187	2,212	(16,975)		2,212	72
73	Fully Depreciated Assets	168,987					168,987	73
74								74
75	TOTALS	$ 2,276,150	$ 155,368	$ 216,408	$ 61,040		$ 1,595,553	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,127,284	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 462,131	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 400,588	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (61,543)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,896,832	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 39,641 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2001 BMW	$ 1,245.00	$ 14,940	17
18	ADMINISTRATIVE	2001 JAGUAR	909.00	10,903	18
19	HSKP, MAINT.	2001 CHEVROLET	775.00	9,300	19
20					20
21	TOTAL		$ 2,929.00	$ 35,143	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 130

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			1,832		1,832
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			3,590		3,590
9	TOTALS		$	$ 5,422	$	$ 5,422
10	SUM OF line 9, col. 1 and 2	(e)	$ 5,422			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	13

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 100,946	$		$ 100,946	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			29,931			29,931	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			139,150			139,150	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				139,320		139,320	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB/RENT/RADIOLOGY/TUBE FEED. 39-2 Other (specify): MEDICAL SUPPLIE 39-2						28,074 3,083		28,074 3,083	13
14	TOTAL			$		$ 270,027	$ 170,477		$ 440,504	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,450,574	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	1,271,173		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	271,235		6
7	Other Prepaid Expenses	14,190		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Escrow & Ins	70,962		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,078,134	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	349,103		13
14	Buildings, at Historical Cost	4,982,301		14
15	Leasehold Improvements, at Historical Cost	1,526,037		15
16	Equipment, at Historical Cost	2,276,150		16
17	Accumulated Depreciation (book methods)	(3,587,870)		17
18	Deferred Charges	254,413		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Amort of Def Mtg Costs	(98,840)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,701,294	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,779,428	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 216,546	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	585		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	117,486		30
31	Accrued Taxes Payable (excluding real estate taxes)	48,670		31
32	Accrued Real Estate Taxes(Sch.IX-B)	82,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 465,287	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	9,231,861		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,231,861	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,697,148	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (917,720)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,779,428	$	48

***(See instructions.)**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,108,481)	1
2	Restatements (describe):		2
3	ROUNDING	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,108,480)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,201,260	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,010,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 190,760	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (917,720)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,645,621	1
2	Discounts and Allowances for all Levels	(271)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,645,350	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	165,919	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 165,919	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	16,064	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 16,064	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	34,284	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 34,284	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	873	28
28a	DISCOUNTS	12,984	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,857	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,875,474	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,318,447	31
32	Health Care	3,057,252	32
33	General Administration	2,409,388	33
	B. Capital Expense		
34	Ownership	1,323,515	34
	C. Ancillary Expense		
35	Special Cost Centers	440,504	35
36	Provider Participation Fee	117,713	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,666,819	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,208,655	41
42	**Income Taxes**	(7,395)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,201,260	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. TAX RETURN CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,240	$ 64,672	$ 28.87	1
2	Assistant Director of Nursing	2,080	2,240	57,536	25.69	2
3	Registered Nurses	29,462	36,423	722,663	19.84	3
4	Licensed Practical Nurses	17,048	19,183	361,479	18.84	4
5	Nurse Aides & Orderlies	95,053	98,417	952,173	9.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	9,964	11,624	151,928	13.07	8
9	Activity Director	4,160	4,693	62,160	13.25	9
10	Activity Assistants	9,686	10,144	80,031	7.89	10
11	Social Service Workers	5,566	7,475	93,030	12.45	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,370	44,573	18.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,577	27,585	218,824	7.93	15
16	Dishwashers					16
17	Maintenance Workers	4,995	5,653	68,616	12.14	17
18	Housekeepers	36,105	37,449	236,678	6.32	18
19	Laundry	18,728	19,868	129,017	6.49	19
20	Administrator	2,080	2,240	109,212	48.76	20
21	Assistant Administrator	4,525	5,040	102,672	20.37	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,051	13,238	180,311	13.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	11,106	12,283	163,658	13.32	31
32	Other Health Care(specify)					32
33	Other(specify) DIR OF MARKET	986	1,116	20,498	18.37	33
34	TOTAL (lines 1 - 33)	293,332	319,281	$ 3,819,731 *	$ 11.96	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,800	1-3	35
36	Medical Director	Monthly	34,350	9-3	36
37	Medical Records Consultant	20	1,000	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	10,099	10-3	39
40	Physical Therapy Consultant	53	2,723	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	8	404	11-3	44
45	Social Service Consultant	22	1,111	12-3	45
46	Other(specify)				46
47	UTILIZATION REVIEW FEES	Monthly	3,250	10-3	47
48					48
49	TOTAL (lines 35 - 48)	199	$ 57,737		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	954	$ 30,700	10-3	50
51	Licensed Practical Nurses	1,270	27,565	10-3	51
52	Nurse Aides	9,006	83,745	10-3	52
53	TOTAL (lines 50 - 52)	11,230	$ 142,010		53

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NANSY GERACI	ADMIN	.0093	$ 109,212
DANIEL WEISS	ASST ADMIN	0	47,672
BARBARA WULF	ASST ADMIN	0	55,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 211,884

B. Administrative - Other

Description		Amount
WESTMONT G. P.	MANAGEMENT FEES	$ 979,100
TOTAL (agree to Schedule V, line 17, col. 3)		$ 979,100
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 1,789
HEALTH DATA SYSTEM	DATA PROCESSING	3,894
EARTHLINK	DATA PROCESSING	261
MID AMERICA	DATA PROCESSING	1,320
KBKB	ACCOUNTING	18,600
RICHARD PEELO	MEDICARE CONSULTANT	4,500
PERSONNEL PLANNERS	UC CONSULTANT	1,819
LARRY CHAMBERS	LEGAL	650
SACHNOFF & WEAVER	LEGAL	2,239
COUNTY CORT	LEGAL	311
LAW OFFICES OF LAWRENCE	LEGAL	4,890
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 40,273

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 106,543
Unemployment Compensation Insurance		28,823
FICA Taxes		286,818
Employee Health Insurance		114,892
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		99,256
EMPLOYEE PHYSICAL EXAMS		5,198
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 641,530

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	10,090
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	6,765
TRUST/FRANCHISE/CONTRIB/ETC	6,431
LICENSES & PERMITS	925
DUES & SUBSCRIPTIONS	7,246
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(6,431)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,765)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,461

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	3,917
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,917

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	7/99	$ 9,577	3 YR	$ 1,596	$ 3,192	$ 3,192	$ 1,597	$	$	$	$	$
2	PAINTING/DECORATIN	7/00	7,646	3 YR		1,274	2,549	2,549	1,274				
3	PAINTING/DECORATIN	7/01	2,495	3 YR			416	832	832	415			
4	PAINTING/DECORATIN	7/02	2,297	3 YR				383	766	766	382		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 22,015		$ 1,596	$ 4,466	$ 6,157	$ 5,361	$ 2,872	$ 1,181	$ 382	$	$

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $6896**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,817** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WESTMONT TERRACE NURSING CENTER, #0025981 09/1/85

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **117,713**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,800	
	REPAIRS & MAINTENANCE		1,248	
			0	6,048
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		5,990	
			0	5,990
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		33,144	
	ELECTRICITY		84,754	
	WATER		80,539	
	CABLE TV - LOBBY		0	
			0	198,437
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		9,971	
	PAINTING & DECORATING		2,297	
	BUILDING REPAIRS		554	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		341	
	ELEVATOR MAINTENANCE & REPAIR		3,868	
	OUTSIDE LABOR		4,750	
	EXTERMINATING SERVICE		3,575	
	FIRE SERVICE		4,251	
			0	
			0	
			0	29,607
7	**OTHER**			
	SCAVENGER		17,777	
	SECURITY SERVICE		2,118	19,895
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	34,350	34,350

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	142,010	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,000	
	PHARMACY CONSULTANT	XVIII B 39-2	10,099	
	UTILIZATION REVIEW FEES	XVIII B __-2	3,250	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	156,359
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,723	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	2,723
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	404	
			0	404
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,111	
			0	1,111
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	5,422	5,422

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,060	2,060
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	979,100	979,100
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	7,264	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	33,009	
			0	40,273
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,765	
	EMPLOYEE WANT ADS	XIX F	10,090	
	CONTRIBUTIONS	VI 20 XIX F	250	
	DUES & SUBSCRIPTIONS	XIX F	7,246	
	LICENSES & PERMITS	XIX F	1,125	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	6,031	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	31,657
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		324	
	EQUIPMENT REPAIR & MAINTENANCE		300	
	OUTSIDE CLERICAL SERVICES		341	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		24,423	
	MESSENGER SERVICE		0	
			0	25,388

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	286,818	
	UNEMPLOYMENT COMPENSATION	XIX D	28,823	
	WORKERS COMPENSATION INSURANC	XIX D	106,543	
	HOSPITALIZATION INSURANCE	XIX D	114,892	
	EMPLOYEE BENEFITS - OTHER	XIX D	99,256	
	EMPLOYEE PHYSICAL EXAMS	XIX D	5,198	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	641,530
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,917	
	TRAVEL	XIX G	0	
			0	
			0	3,917
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		63,615	63,615
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		161,370	161,370
27	**OTHER**			
	BAD DEBTS	VI 24	19,816	
			0	19,816

GRAND TOTAL COLUMN 3 OTHER 2,429,072

WESTMONT CONVALESCENT CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	245,139	PATIENT MEALS	213522
LESS SALES TAX	(854)	ADD EMPLOYEE MEALS	0
NET FOOD	244,285	TOTAL MEALS/YEAR	213522
TOTAL PATIENT CENSUS	71,174	NET FOOD	244285
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	213522
TOTAL PATIENT MEALS	213522	COST PER MEAL	1.14
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		